**Module Four Assignment**

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1. **A) what is mental illness?**

A **mental disorder**, also called a **mental illness** or **psychiatric disorder** is a behavioral or **mental** pattern that causes significant distress or impairment of personal functioning. ... **Mental disorders** are usually **defined** by a combination of how a person behaves, feels, perceives, or thinks.

b) **Briefly describe the major categories of mental illness and their treatment**

Mental illnesses account for more disability in developed countries, including South Sudan, than any other group of illnesses. Nearly half of adult South Sudanese will develop at least one mental illness during their lifetime. The most common mental illnesses in adults are anxiety and mood disorders. Schizophrenia, which occurs in about 1 percent of the population, is characterized by profound disruption in cognition and emotion and often includes hallucinations and delusions. Genetic factors are important in some mental disorders, including schizophrenia, autism and bipolar disorder. Most mental disorders are also influenced by environmental factors. PTSD which is post traumatic stress disorder is clearly caused by extremely stressful events. Eating disorders are caused by a complex interaction of genetic, biological, behavioral, and psychological factors. Most people with mental disorders do not seek treatment, although effective treatments do exist, including medications and psychotherapy.

The major categories of mental illness listed in 1999 by Surgeon General’s report, for Mental Health are four: 1- anxiety, 2- psychosis, 3- disturbances of mood, and 4- disturbances of cognition. These four categories are broad, heterogeneous, and somewhat overlapping. Any particular patient may manifest symptoms from more than one of these categories. Thus mental illnesses are sometimes hard to diagnose and, consequently, hard for epidemiologists to count.

**Anxiety** is a vitally important physiological response to dangerous situations that prepares one to evade or confront a threat in the environment. However, inappropriate expressions of anxiety exist if the anxiety experienced is disproportionate to the circumstance or interferes with normal functioning. Examples include phobias, panic attacks, and generalized anxiety. Other manifestations of anxiety include obsessive compulsive disorder and post-traumatic stress disorder (PTSD).

**Psychosis** Disorders of perception and thought process are considered to be symptoms of psychosis. They are most characteristically associated with schizophrenia, but psychotic symptoms can also occur in severe mood disorders. Among the most commonly observed psychotic symptoms are hallucinations—sensory impressions that have no basis in reality—and delusions—false beliefs held despite evidence to the contrary, such as paranoia.

**Disturbances of Mood** characteristically manifest themselves as a sustained feeling of sadness or hopelessness, major depression or extreme fluctuations of mood bipolar disorder. Mood disturbances are also associated with symptoms like disturbances in appetite, sleep patterns, energy level, concentration, and memory. Perhaps most alarming, major depression is often associated with thoughts of suicide.

**Disturbances of Cognition** The ability to organize, process, and recall information, as well as to execute complex sequences of tasks, may be disturbed in a variety of disorders. Notably, Alzheimer’s disease is a progressive deterioration of cognitive function, or dementia.

Treatment

Drugs to boost neurotransmitter levels, such as Aricept, Razadyne and Exelon

A drug called memantine, which works via a different pathway to regulate the activity of the neurotransmitter glutamate to improve memory and learning

Occupational therapy that focuses on teaching the patient strategies to minimize the effect that cognitive impairment has on day-to-day living

Environmental approaches, such as reducing clutter and noise around the patient to make it easier to focus on tasks and reduce confusion and frustration

Most people with mental disorders do not seek treatment. In part this is because they do not know that there are effective treatments. In part it is fear of the stigma of acknowledging the problem. Above all, the major deterrent is the cost of care. In general, insurance coverage of mental health care is inferior to that of physical health. In the past, hospitalization was the norm for serious mental illness. People were sent to asylums, where they frequently endured poor and occasionally abusive condition. Patients became excessively dependent and lost connection to the community. More recently, inpatient units are used for crisis care, focusing on reducing the risk of danger to self or others and rapid return of patients to the community. Housing is often a major problem for people with severe mental illness, who often tend to be poor. It is estimated that up to one in three individuals who experience homelessness has a mental illness.

2. **Explain how social factors affect the health outcomes of individuals/communities**

**Health of Minority Populations**

Race and ethnicity have been seen to profoundly affect health of individual/communities. Most data on health status of different population groups show that the health of individual constituting about 17 percent of the population is poorer than that of communities. Hispanics are a heterogeneous group, and their health status varies among different subgroups. American Indians generally have poorer health indicators than whites, while Asian Americans have better health status.

While the overall health of the U.S. population has improved over the past decades, health disparities among racial and ethnic groups have persisted. Life expectancy at birth in 2013 was 79.1 for whites and 75.5 for blacks. The infant mortality rate of blacks was more than double that for whites and the rate for American Indians/Alaska Natives was 1.6 times higher than that of whites. Mortality from diabetes is almost twice as high in blacks as in whites and 1.8 times as high in American Indians as in whites. Black men die of prostate cancer at 2.3 times the rate of white men. The death rate from HIV/AIDS is almost 7 times higher among black men than white men, and 14 times higher for black women than white women, way out of proportion to their percentage of the population.

The health disparities may be accounted for in part by the lower SES of blacks, who live in households with median incomes $17,000 less than the average for the nation. Over 27 percent of blacks were living in poverty in 2013, as compared with 9.6 percent of non-Hispanic whites. Blacks have less education on average than whites, and they have higher unemployment rates. The reasons for the socioeconomic disparities are complex and somewhat inaccessible to public health interventions. Moreover, the relationship between socioeconomic status and health is not entirely understood. Nevertheless, public health must find ways to improve the health of groups that have historically been disadvantaged economically, educationally, and politically. The federal government predicts that by 2050, nearly half of Americans will belong to racial and ethnic minorities. If the health disparities are not remedied, the overall health of the U.S. population is likely to decline.

Public health interventions aimed at improving the health of minority groups include efforts to influence their health behaviors. These efforts begin with attempts to understand what factors influence health and health behavior, how these factors may affect people of various ethnic and racial groups differently, and what kind of interventions can be effective in modifying these factors. This chapter and later chapters that consider specific health behaviors will examine how minority groups differ from the majority white population and how those differences may be related to the observed disparities in health.

**Stress and Social Support**

A number of psychological factors have been found to affect individual health, some of which may have a role in the health effects of SES. One of these factors is **stress**, which is due to the adverse physical and social conditions associated with lower SES, which may act both directly, by affecting physiological processes, and indirectly, by influencing individual behavior. Early evidence of the health effects of stress came from observations that widows and widowers seemed to have an unusually high risk of dying soon after the death of their spouses. Several studies in the 1960s and 1970s found that mortality rates of survivors are 40 percent to 50 percent higher during the six months after the death of a spouse compared to the mortality of married people of the same age. These studies were expanded to include the effects of other stressful life events such as death of other family members, divorce, and loss of a job, all of which were found to increase the risk of illness or death.

Stress is well established as a contributor to heart disease, a relationship that has been demonstrated in a variety of epidemiologic studies. A particularly convincing example is a study of the male employees of two banks. At first, the two groups were similar, but one bank changed its management policies to become commercial. The employees of the commercial bank had to deal with considerable competition, risk, and responsibility for investing funds; employees of the other bank, a semipublic savings bank, had less 5 competition and fewer responsibilities. Over a 10-year period, the employees of the commercial bank were found to have 50 percent higher rates of heart attacks and sudden death.

Experiments on animals ranging from rats to baboons have found that various psychosocial stresses induce physiological changes such as decreased immune response and increased atherosclerosis. A 1991 experiment on humans demonstrated that stress suppresses the immune response in humans. In that experiment, investigators measured levels of psychological stress in 420 healthy volunteers, and then administered nasal drops containing cold viruses to all but a small control group. They found that the subjects whose stress levels were higher were more likely to be infected with cold viruses and more likely to develop colds, with symptoms including sneezing, coughing, eye watering, nasal discharge, sore throat, and increased use of tissues. A whole new field of research called psychoneuro-immunology has arisen to study the impact of stress on health.

There are many reasons why lower SES exposes people to greater life stress. Daily hassles are greater at lower levels on the SES hierarchy: Cars break down, landlords complain about late rent checks, child care is unreliable, and officials are rude. Members of racial and ethnic minorities may be exposed to incidents of racial prejudice. These minor but constant stresses may be as debilitating as such major life events as deaths in the family. Higher income and education provide resources that help to buffer the impact of life’s hassles, thereby protecting health.

A number of factors can help people cope with life’s stresses. Money, of course, can solve a multitude of problems. Education is important because it provides the information and skills to solve problems. Family and friends can also help by providing both emotional and instrumental assistance. In fact, **social support** has proven to be surprisingly significant in determining an individual’s health.

Early evidence for the influence of social support on health came from an epidemiologic cohort study conducted on residents of Alameda County in California. Persons aged 30 to 69 were surveyed in 1965 on their physical, mental, and social well-being as well as their health-related habits such as exercise and the use of cigarettes and alcohol. They were also asked about their social networks, such as marital status, number of close friends and relatives, church membership, and affiliation with other organizations. Death certificates were then monitored over the next 9 years to assess mortality rates and, in 1974, a follow-up survey was conducted on survivors to assess their health status.11

The study, as expected, found a strong association between certain unhealthy behaviors and higher mortality rates. More surprising, the study also found that an individual’s health status and risk of dying were strongly associated with the extent and nature of his or her social network. This was true for both men and women and for individuals of high SES and low SES. The association remained true even after unhealthy behaviors were taken into consideration. Throughout the socioeconomic spectrum, men and women with few social contacts had mortality rates two to three times higher than those with many social connections.

Many more recent studies have supported the conclusions of the Alameda County study. Absence of social support has been related to an increase in coronary heart disease, complications in pregnancy and delivery, suicide, and other unhealthy outcomes. Why social support should have such a broad and consistent effect on health is very poorly understood. It probably acts in part through its ability to buffer stress. A better understanding of the relationship between social support and health may come from research in the field of psychoneuro-immunology.

3. **Explain how psychosocial factors affect health behavior**

Psychosocial factors stress, hostility, depression, hopelessness among others affects our health behavior in very many ways as explain below:

“**Psychosocial**” **factors** such as stress, hostility, depression, hopelessness, and job control seem associated with physical **health**—particularly heart disease. ... Such **factors** include many mental states, **psychological** traits, or aspects of the social environment with a negative connotation.

Because health is so strongly affected by behavior, it is important for public health advocates to understand what influences people to behave in healthy or unhealthy ways. The social and behavioral sciences offer insights into why people behave as they do, and they provide a basis for developing interventions aimed at persuading people to change their behavior.

There is evidence that factors such as race, gender, marital status, and especially SES influence health, and the reasons for these differences are likely to be social. Life expectancy, infant mortality, and mortality rates from a variety of diseases vary profoundly among different racial and ethnic groups. Stress, which may be brought on by social factors, has an adverse effect on health for a number of reasons. Social support has been found to have a positive effect on health, probably in part by providing a buffer against stress. The health of black Americans tends to be poorer than that of the white majority. Health data on the population is usually analyzed by race and ethnicity, and public health efforts focus on understanding the disparities and trying to eliminate them.

Theories of health behavior include the health belief model and the theory of self-efficacy. Both theories focus on the individuals’ attitudes and beliefs as determinants of their behavior. The trans-theoretical model of stages of change can be used in health education programs to promote behavior change. A broader perspective is provided by the ecological model of health behavior. This model considers all the levels of influence that may affect the individual’s attitudes and beliefs, including interpersonal relationships such as family and friends, institutional influence such as school and work, the larger community and its values and beliefs, and public policy including laws and regulations.

The most effective public health intervention programs influence people’s beliefs at several levels with the goal of creating a social environment favorable to healthy behavior. The San Francisco AIDS prevention program is an example of an effective program that succeeded in significantly reducing the transmission of HIV early in the epidemic. Evidence shows, however, that in order to maintain the success of such a program, intensive public health efforts must be maintained, both to prevent relapses into unhealthy behavior and to educate new generations of at-risk people.

Increasingly, public health advocates realize that the most effective ways of improving health-related behavior of individuals is to focus on involving whole communities in improving the social and physical environment to be more conducive to healthy behavior.

**4. Identify and explain three major threats to public health**

These **threats** include immediate crises, such as **the** AIDS epidemic; enduring problems, such as injuries and chronic illness; and growing challenges, such as **the** aging **of** our population and **the** toxic by-products **of** a modern economy, transmitted through air, water, soil, or food.

The three major threats to public health are mentioned and describes below

Taxes as a public health measure

Tobacco control program

Food and Drug Administration -FDA

**Taxes as a Public Health Measure**

Antismoking activists, supported by economics research, have concluded that one of the most effective measures to discourage young people from smoking is to raise the tax on cigarettes. One reason is that a pack of cigarettes represents a more significant proportion of a teenager’s disposable income than it does for adults, and the higher price is likely to have more impact on someone who is not yet addicted. Low income and minority smokers are also sensitive to price.

Recent research on teenage smoking suggests that teenagers are indeed sensitive to price. For example, after Philip Morris cut the price of Marlboro cigarettes, a brand favored by young people, by 40 percent in April 1993, the proportion of teenagers in 8th, 10th, and 12th grades who smoked rose from 23.5 percent to 28 percent in 1996. Other studies have shown that a 10 percent increase in price reduces the number of teenagers who smoke by approximately 7 percent to 12 percent. “Raising tobacco taxes is our number one strategy to damage the tobacco industry,” an American Cancer Society executive was quoted as saying. “The industry has found ways around everything else we have done, but they can’t repeal the laws of economics.

Raising taxes on cigarettes is effective in reducing smoking among adults as well. In 1989, California increased cigarette taxes from 10 cents to 35 cents per pack. The law specified that 20 percent of the proceeds were to be designated for programs designed to prevent and reduce tobacco use, especially among children. Surveys conducted before and after implementation of the tax increase found that the prevalence of cigarette smoking among adults in California was reduced from 22.7 percent in 1988 to 20.0 percent in 1992 to 16.9 percent in 1995 to 13.3 percent in 2008. It is difficult to determine the share of the decline that can be attributed to the price increase as compared with other antismoking measures, including indoor smoking bans and the antismoking campaign funded by the tax.

In recent years, state and local governments have found that raising taxes on cigarettes is a painless way of closing budget shortfalls, and many states have followed this policy. In 2015, for example, New York had the highest rate, with a tax of $4.35 per pack. By contrast, tobacco-producing states have low cigarette taxes: Virginia’s rate was 30 cents per pack, and Missouri’s rate, the lowest, was 17 cents. California, a leader in raising cigarette taxes for public health goals, had fallen to aPublic Health Enemy Number One: however taxes as a public health measure are major threat to public health measure.

**Tobacco Control Program**

Despite California’s failure in recent years to maintain its leadership in tobacco control efforts, its voter-initiated program begun in 1989 with a 25-cent tax increase on cigarettes, has proved successful in maintaining low smoking rates statewide. The initiative mandated mass media anti-tobacco advertising as well as school and community education and intervention activities. It also mandated that the effectiveness of the program be evaluated after a decade. Thus, the California experience has provided evidence on what methods are effective in reducing smoking.

The tax increase itself contributed to the success of the program, as discussed in the previous section. Immediately after the increase was implemented, cigarette consumption declined significantly in California compared with the rest of the nation. In 1994, the California legislature passed a law prohibiting smoking statewide in all workplaces except bars, taverns, and casinos. The law has since been strengthened to include these workplaces as well. Overall, per capita cigarette consumption in California fell dramatically from 110 packs per capita annually in 1988/89 to 30 packs per capita in 2013/14. This reduction was achieved by a combination of a reduction in the number of smokers and reduction of the number of cigarettes each smoker consumed per day.

In California, according to the CDC’s Behavioral Risk Factor Survey, the prevalence of smoking was 13.7 percent in 2011, compared to 21.2 percent in the nation as a whole. California’s anti-tobacco campaign suffered budget cuts after the first few years, and tobacco companies stepped up their political efforts to oppose the state’s control measures, as well as their advertising and promotion of cigarettes; but the permanent changes in policy, as well as additional tax increases, have helped California to maintain its lead over all other states except Utah in keeping smoking levels relatively low.

California’s campaign included an aggressive advertising component, which contributed significantly to the campaign’s overall success. Studies of the effectiveness of antismoking messages have shown that some messages are much more effective than others. In fact, some programs sponsored by the tobacco industry, which are presented as smoking prevention efforts, have been shown to make smoking more attractive to youths. Examination of industry documents, discussed in the next section, has found that the industry has purposely used these “forbidden fruit” messages to generate good public relations and fight restrictive legislation without actually discouraging youth smoking.

The evaluation component of California’s media campaign identified which antismoking messages were most effective in reaching youth. Researchers found that 25 the message most effective in reaching both youths and adults is that “Tobacco industry executives use deceitful, manipulative, dishonest practices to hook new users, sell more cigarettes and make more money. One such successful ad, called “Nicotine Sound-bites,” showed the actual footage of tobacco executives testifying before Congress in 1994, raising their right hands and swearing that nicotine is not addictive. Ads with this message made both adults and teenagers angry, because no one likes to learn that they are being manipulated.

Another message that was found to be effective among both adults and teens was that second-hand smoke harms others. One ad portrayed a boy smoking, sitting with his little sister watching television. The little girl begins coughing and smoke comes out of her mouth. In the early 1990s, California also ran ads that encouraged quitting and provided information on smoking cessation programs, including toll-free quit lines; calls to the quit lines dramatically increased. Ads with some other messages, including those that focused on health effects, were found to be ineffective.

Researchers concluded that, to be effective, anti-tobacco advertisements need to be “ambitious, hard-hitting, explicit, and in-your-face. The industry recognized the effectiveness of the ads and worked hard to limit them. R. J. Reynolds threatened to sue the California Department of Health and the television stations that ran the Nicotine Sound-bites ad; the lawsuit was not filed, but the ad was later dropped. During the state campaign, the tobacco industry tried to counter the anti-tobacco efforts by increasing spending in California on advertising, incentives to merchants, and promotional items. One study calculated that after 1993, the industry spent nearly $10 for every $1 spent by the state.

**(FDA) Food and Drug Administration Regulation**

The original agreement negotiated by the state attorneys general and the tobacco companies contained a provision allowing the FDA to regulate tobacco. Because that agreement was not approved by Congress, the MSA did not contain such a provision.

There are many advantages to giving regulatory authority over tobacco to the FDA. Until 2009, there were no legal restrictions concerning ingredients in tobacco smoke or on labeling or advertising concerning health claims by the companies. There is evidence, for example, that companies manipulated nicotine levels in tobacco to promote addiction, and they added ammonia to increase the effect of the nicotine. Tobacco smoke contains toxic chemicals such as nitrosamines and arsenic in addition to the tars known to be carcinogenic. It also contains radioactive polonium, which is not widely recognized. In fact, the American Legacy Foundation has focused on some of these toxic ingredients in their antismoking ads.

Finally in 2009, after previous attempts had failed, Congress passed and President Obama signed the Family Smoking Prevention and Tobacco Control Act. The law gives the FDA authority to regulate tobacco products and to restrict advertising and promotion. It requires larger and more graphic warning labels on cigarette packages, and it forbids tobacco companies from sponsoring sporting events. The law requires the disclosure of ingredients of cigarettes, as is done with food. It gives the FDA authority to require the removal of harmful ingredients, and to regulate health-related claims made by the companies, insisting that such claims be proven. The truth-in-advertising provision makes it possible for cigarettes to be made safer, so that smokers who cannot or will not quit would suffer less harm. Unless the government has the authority to verify claims, tobacco companies could continue to label their products “light” or “safer” without needing to actually reduce the hazards of smoking. One proposed advantage of giving the FDA regulatory authority would be to allow the agency to gradually reduce the amount of nicotine allowed in cigarettes to make them less addictive and to taper smokers off the addictive drug.

The new law bans candy-flavored cigarettes, designed to appeal to young people. However, menthol was not included in the banned flavorings. Menthol masks the harshness of inhaled smoke and appears to ease the initiation of smoking among youths. It is also popular among black smokers, three-quarters of whom smoke menthol cigarettes, while only 25 percent of white smokers choose the menthol flavoring.

“The key to public health action on the tobacco front seems to lie in combining strategies to discourage children from smoking and in producing a safer and less addictive cigarette for those who cannot, or will not, resist the temptation to smoke,” wrote the ethicist George Annas in January 1997 when the possibility of a negotiated settlement was first being considered. Whether Congress or the courts or both will finally make possible the demotion of tobacco as public health enemy number one remains to be seen. Therefore tobacco is major threat to public health

**What are some of the psychosocial interventions for mental health and substance use disorders in your country?**

It has been recognized that the management of severe mental illness should not only involve medication, but psychosocial interventions (PSI).

These interventions draw techniques from cognitive Behavioral therapies (CBT) and educational theories.

They assume that there is a complex interplay between biological, environmental and sociological factors and that ambient stress together with certain life events may trigger an onset or relapse of mental health problems in some people (Neuchterlein and Dawson, 1984; Zubin and Spring, 1977).

The use of PSI is based on a diagnostic assessment of the patient’s psychopathology. Psychosocial interventions include:

* Engagement and outcome-orientated assessment;
* The family’s assessment of the patient’s needs;
* Psychological management of psychosis – CBT, coping strategy enhancement, self- monitoring approaches and training in problem-solving;
* Medication management, via motivational interviewing techniques.

Research has suggested that CBT, family intervention and medication management are promising

interventions for ameliorating a client’s experiences of psychosis (Gould et al, 2001; Kuipers, et al 1997; Kempet al, 1996; Mari et al, 1996). Nevertheless, a resentment-analysis highlighted that data supporting the wide use of CBT was far from conclusive (Cormac et al, 2001) and there is a need to be cautious about advertising it as the universal remedy for psychosis(Paley and Shapiro, 2002; Cormac et al 2001).

After four months she was persuaded to attend the local community mental health centre but became suspicious of the psychiatrist who offered to increase her medication. Her exhausted mother witnessed

Andrea’s distress and pleaded with staff to try a different approach and negotiated Andrea’s referral to a

Community psychiatric nurse (CPN). While waiting for aCPN appointment Andrea’s mental state deteriorated further and she was sectioned and admitted to an acute ward. On arrival, her parents requested an urgent review. Andrea remained aloof, paranoid and was irritable whenever she was approached. Low staffing levels hampered nurses’ attempts to establish a relationship with her. Andrea said that she hated the manner in which she was being treated and spoken to, and voiced paranoid ideas about her parents. As a consequence, staffs were reluctant to offer Andréa’s parents anything other than superficial information.

Events leading up to an admission to an acute psychiatric ward and the admission itself can be daunting for all involved, often precipitating powerful emotions. It is helpful to examine how it is experienced from different perspectives.

In the past Andrea had had negative experiences of psychiatric treatment and inpatient services. On the ward there was limited time to outline her perspectives of her illness, discuss symptoms and/or get to know individual staff members. There was no opportunity to reflect upon Andrea’s strengths and coping strategies that had been learnt between admissions.

The family felt their understanding of the illness, knowledge of stress indicators and detection of early warning signs were undervalued. There was little opportunity to influence the treatment plan and a perception that they had done something wrong.

Staff on the ward felt there was limited time for listening to the experiences of patients and their families. There was also a conflict involved in maintaining client confidentiality and keeping families informed and involved. Overcoming the obstacles to PSI Psychosocial interventions can hold the key to communicating and engaging with clients and families. The difficulty is in balancing the needs of both. The challenge for acute inpatient services is how to develop and sustain working relationships and alliances when the ward is understaffed, over-stretched and/or confronted by inflexible working systems. Interpersonal skills are key in this respect. In Andrea’s case, it was important to find the time to engender a supportive relationship and let her know that her concerns were being taken seriously. Despite calls for PSI to be utilized in acute settings, many practitioners perceive PSI to be too mechanical and time consuming. Inflexible shift systems, low staffing levels and a general lack of confidence, skill and experience appear to leave some practitioners feeling unable to tailor PSI to meet the needs of the clients and their families while they are inpatients (Repper and Brooker, 2002). The following case study outlines how staff overcame perceived and actual service obstacles to engage one client and her family using PSI.

Case study Andrea was diagnosed with schizophrenia shortly after her 21st birthday. After inpatient treatment she remained in remission for seven years. With family support, she gained a university place but two years into the course her boyfriend left her. She lost interest in studying, began drinking heavily and replaced her prescribed medication with illegal drugs.

Andrea returned home but became paranoid; believing the world and her family was against her.

Her allocated nurse negotiated with the ward manager some flexible ‘off Rota’ time and over three, one-hour sessions, they got to know each other. They also used the time to gain a baseline of Andrea’s symptoms and review the efficacy of antipsychotic medication treatment by conducting the Liverpool University narcoleptic side-effect rating scale (Day et al, 1995) and KGV (M) symptom severity scale (Krawiecka et al, 1977).

The results revealed that Andrea was experiencing some side-effects from the medication such as weight gain, dry mouth and an overwhelming feeling of restricted movement. She was also depressed and experiencing some paranoid thoughts – but her paranoid symptoms did not rate as highly as the staff had previously perceived. Through careful questioning Andrea disclosed she had felt vulnerable and frightened of readmission because a male patient had verbally threatened her during a previous admission. This enabled Andrea’s nurse to present formal data to the care team and influence the decision to reduce her medication levels, as well as change staff attitudes. Family involvement many families are initially very suspicious of mental health professionals when they are asked to offer support, especially if in the past they have experienced a crisis, called for help and not gained an appropriate response. In Andrea’s case her parents had ‘stalled’ her admission, sought a second opinion, did not

accept superficial information from staff and subsequently faced negative attitudes and a reputation

for being interfering and troublesome.

In Standard 6 of the *National Service Framework for Mental Health* (Department of Health, 1999), all careershave a right to have their needs assessed and beinvolved in their relative’s treatment plan. In Andrea’scase it was important to address the negativeassumptions that both parties had developed abouteach other. The team felt constrained by Andrea’s wishnot to have her parents involved and was divided aboutthe issue of confidentiality. Utilizing ideas generated byFurlong and Leggart (1996) it was deemed important togain a comprehensive account of the family’s experience.

A meeting was arranged to assess the family’s needs and devise collaborative intervention strategies. These included developing an understanding of Andrea’s early warning signs and crisis planning to pre-empt problems.

This provided a structure for giving practical support and information and for communicating the family’s needs to the rest of the multidisciplinary team.

**Stress vulnerability model** The stress vulnerability model (Zubin and Spring, 1977) was explained to Andrea and her family. Stressful events were linked to Andrea’s personal experiences of increased psychosis. Andrea and her family were shown how they could anticipate and manage potentially stressful experiences.

Andrea’s early warning signs were recorded on a chart (see Table 1), incorporating the progression of

Symptoms and outlining what actions should be taken to prevent an escalation of Andrea’s problems. Conclusions this case study has highlighted how PSI can be incorporated into the routine clinical practice of an acute inpatient ward. Achieving this in busy inpatient wards will never be easy,

6. **Describe two psychological models of health behavior**

While public health does not have much power to change people’s SES, stressful life events, or social networks, it is hoped that understanding how these factors affect health may permit more effective interventions to promote healthier behavior. With this goal, social and behavioral scientists have proposed various theories and models attempting to explain how psychosocial factors affect health-related behavior. Some of these theories focus on individual psychology, while others attempt to explain the effect of the social environment on individual behavior. The goal of these analyses is to understand the most effective ways to promote healthier behavior.

The classic frame of reference for understanding health behavior, and especially behavior change, is the **health belief model**. Assuming that people act in rational ways, the health belief model specifies several factors that determine whether a person is likely to change behavior when faced with a health threat. These factors are (1) the extent to which the individual feels vulnerable to the threat, (2) the perceived severity of the threat, (3) perceived barriers to taking action to reduce the risk, and (4) the perceived effectiveness of taking an action to prevent or minimize the problem.

Based on the health belief model, the public health approach to changing behavior would be to convince people that they are vulnerable, that the threat is severe, and that certain actions are effective preventive measures. For example, surveys of low-income minority women who had not had mammograms found that many had misperceptions about the disease. Some women underestimated their susceptibility to breast cancer (factor 1); others were embarrassed or afraid of the pain or radiation involved in a mammogram (factor 3); and others felt that cancer was not curable and therefore there would be no point in diagnosing it early (factor 4). Screening rates among these women could be improved by counseling that included personally tailored messages that addressed the women’s beliefs and concerns.13

Another important concept in understanding health behavior is **self-efficacy**, the sense of having control over one’s life. People who are confident that they can control their lives are said to have high self-efficacy. People who believe their lives are subject to change or external forces are said to have low self-efficacy. Self-efficacy is often added as a fifth factor in the health belief model. People are more likely to adopt healthy behavior if they are confident that they have the ability to do so.13

A sense of control is beneficial for health in a number of ways. Clearly, it reduces stress. A number of studies in both humans and animals have shown that an individual’s perception of the stressfulness of an adverse event can be reduced by two factors: knowledge of when the stressful event will occur and the ability to regulate the timing and intensity of the event. This knowledge and ability give the individual a sense of control, or self-efficacy. The lowest self-efficacy is seen in people (or animals) who have experience of being unable to avoid noxious events, especially if they have repeatedly tried and failed. They may develop a pattern of “learned helplessness,” a pattern described as a “numbed acceptance of a negative situation, so that an individual no longer tries to change that situation for the better because he or she does not expect those efforts to make any difference.”14(p.44)

A number of studies have shown that people with high self-efficacy are more likely to engage in health-promoting behavior than those with low self-efficacy. An attitude of learned helplessness is common in people who have repeatedly tried and failed to quit smoking or lose weight.

A great deal of research has been focused on how to increase people’s self-efficacy, thereby helping to motivate them to practice healthy behaviors. An individual’s self-efficacy is increased by previous

Successful performance of the behavior in question. It may also be increased by seeing others successfully perform the behavior, especially if the observed behavior is being performed by someone similar to themselves. For example, the most successful school drug prevention programs include role-modeling, small group exercises, and skills practice to teach students how to identify and resist internal and external pressures to use drugs. These programs have been found to be much more effective in enhancing students’ self-efficacy to resist drugs if they are led by older teens, with whom they can identify, rather than by adult health educators.15

A theory that has proved widely useful in health education is the **trans-theoretical model**, which envisions change—for example, smoking cessation or adopting a healthy diet—as a process involving progress through a series of five stages: pre-contemplation, contemplation, preparation, action, and maintenance. People in the pre-contemplation stage have no intention to change their behavior; the first step in getting them to change involves consciousness rising to increase their awareness that their behavior is unhealthy and should be changed. In the second, contemplation stage, the person is more aware of the benefits of change, but is also very aware of the difficulties and barriers to change and still is not ready to take action. The third step is preparation, when a person has decided to make the change and has planned concrete actions he or she could take, such as signing up for a class, discussing the plan with their physician, or buying a self-help book. The fourth step, action, requires that individuals actually modify their behavior by abstaining from smoking or adhering to a healthier diet. Finally, maintenance is the stage in which people have achieved the healthier behavior but must strive to prevent relapse.16 knowing which stage an individual has reached can help a physician or health educator move him or her along to the next stage.

The health belief model and the Trans theoretical model are not contradictory; they are merely alternative ways of looking at what may be the same psychological factors. Both models can be useful in designing public health messages aimed at changing behavior.

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